



Challenges in Availability and Utilization of Clinical services for Rape Survivors in a post conflict setting: a case study of in Northern Uganda

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Background:

Consequences of 20 years of conflict in Northern Uganda:

- Destroyed individuals, families and communities
- Over 2million people displaced in camps; Now about 80% back home or in the satellite camps near their homes.- New challenges
- War increased vulnerability to GBV, including sexual violence and HIV
- Disrupted delivery of health services
- Weakened rule of law

GBV Northern Uganda

- GBV cases *reported* include rape, child sexual abuse (defilement), domestic abuse, early and forced marriage
- Barriers to reporting: fear, social stigma, shame, and lack of confidential, accessible, and appropriate services
- In Uganda, of female survivors of violence who sought help only 4.9% sought help from a doctor/medical personnel (UDHS, 2006)



GBV Northern Uganda

Uganda Demographic Health Survey 2006

% of women (aged 15-49) who have ever experienced sexual violence

Northern Uganda	32%
IDP camps	28%
Uganda (national)	39%

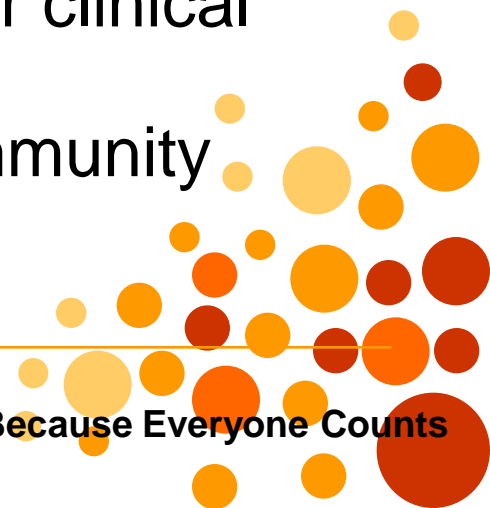
% of ever married women age 15-49 who have ever experienced *physical or sexual* violence by husband /partner

Northern Uganda	58%
IDP camps	54%
Uganda (national)	59%



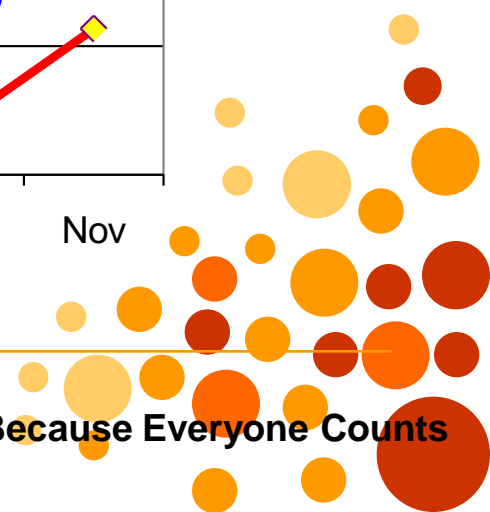
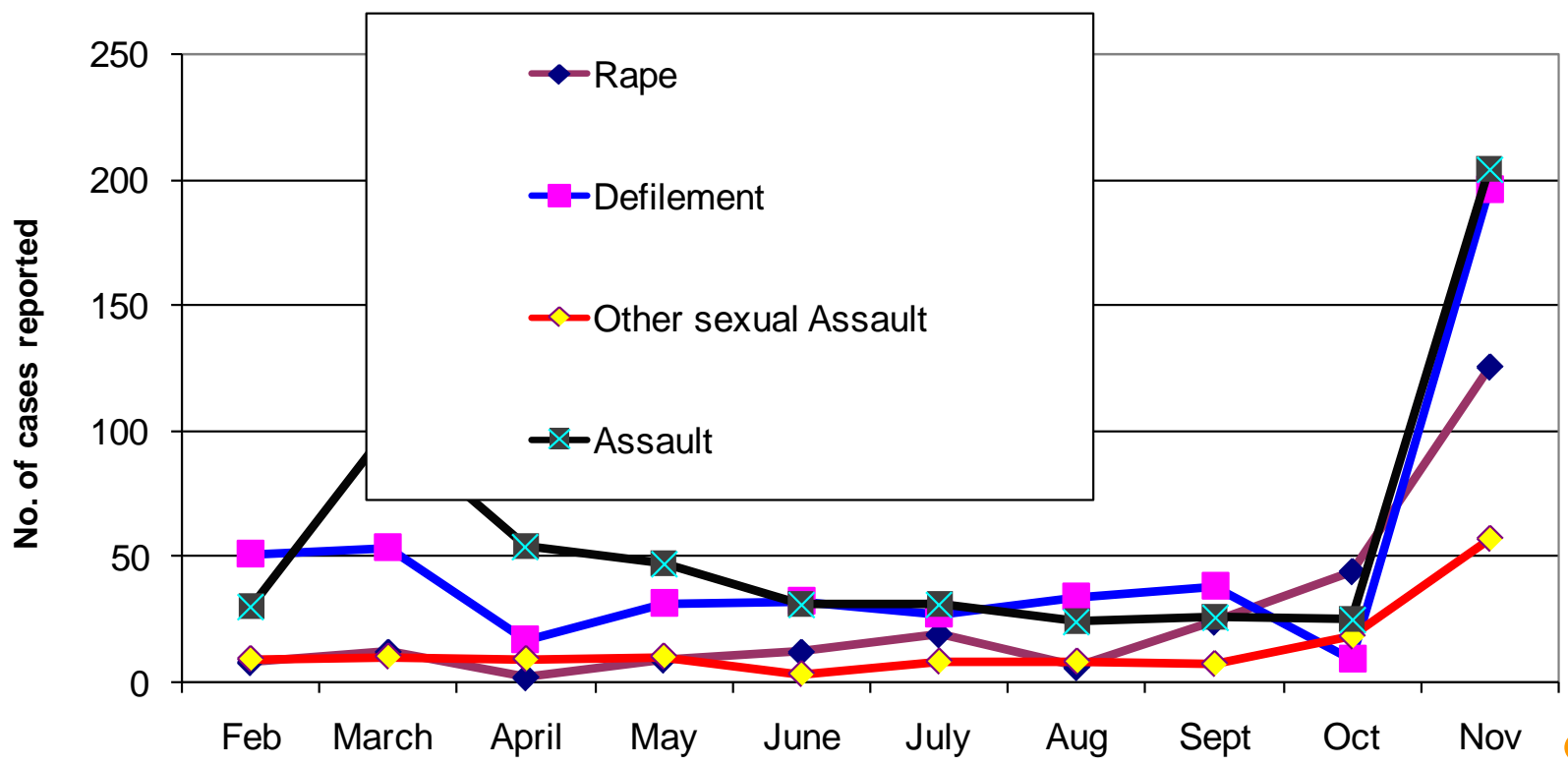
Programmatic Responses to GBV

- Training health workers – HWs from health units (levels 2 – 4 and hospitals) trained in clinical management of rape and GBV concepts
- Provision of supplies - 55 rape management kits (PEP and ECP) distributed to government health facilities
- Case management services provided by humanitarian partners
- Development of national guidelines for clinical management of rape
- Sensitization of communities and community leaders





GBV Cases Reported to Service Providers in Gulu and Amuru Districts 2007



Health facilities:

- Provide a neutral location for treatment, information, counseling and testing
- Serve as a first point of entry for referral services

However,

- Barriers to access persist, especially at rural units
- Quality of care frequently reported to be low
- Gulu District GBV Working Group identified gaps in monitoring of clinical response services



Objectives

UNFPA partnered with **GHWN** to assess

- **Availability** of services
- Health care workers' **knowledge and skills** to provide medical care to GBV survivors
- Health care workers' **knowledge of referral pathways**

Methodology

- **Facility observation** (11 health units - 10 public and 1 private) of health units supplied with rape management kits
- **In-depth interviews** with 24 health workers (7 male, 17 female) from those 11 health units
- **Focus group discussion** with social workers from various agencies working with rape survivors who regularly refer and accompany survivors for medical treatment

Qualification of Health Workers Interviewed

Clinical officer	5
Midwife	9
Enrolled Nurse	5
*Nursing assistants	4
*(VHT) Village Health Educator	1
Total	24

*targeted only those HW trained, but in some Centres NA run the units



FINDINGS: HW Training

- 13 HWs (54%) had received some basic training on gender-based violence
- 10 HWs (42%) had been trained on clinical management rape

However....

- *Only 46% of HWs had served more than 1 year at their duty stations*



FINDINGS: HW Knowledge

- 23 (96 %) and 17 (71 %) of the 24 respondents mentioned rape and defilement respectively as common forms of GBV
- 63% of HWs were familiar with the guiding principles but only 58% listed confidentiality and only 25% listed safety
- More than half of the respondents mentioned that ***any trained health care worker*** can perform a medical exam for a rape survivor
- *In practice, a medical doctor's signature is required on the Police Form 3, which provides legally binding medical evidence of rape*

FINDINGS: HW Knowledge

- Mixed knowledge of appropriate time frame for administration of treatment
- Only 46% of HWs named referral as a service that the health unit should provide

PEP	92%
ECP	21%



FINDINGS: HW Experience

- **All** HWs interviewed expressed fears of legal implications associated with treating a survivor
- Most HWs prefer to refer survivors to medical doctor (medical officer or gynecologist)



FINDINGS: HW Experience

- 15 of the 24 HWs had treated a survivor of rape (mainly treatment of injuries and counseling)
- Of the 15 who had treated a survivor, only 9 (60%) had received training on clinical management
- Only one HW had ever administered PEP, and only 5 had ever given ECP
- Over half of HWs referred patients to seek treatment elsewhere

FINDINGS: Service Availability

- Only HC IVs and hospital are open 24/7
- All health units had supplies and services (PEP, ECP, STI Prophylaxis, Tetanus Toxoid, counseling, etc) readily available
- 20% of health workers did not know the supplies were available in their own unit
- Only half of HWs knew that MOH Guidelines, medical history and exam forms were available in their unit



FINDINGS: Focus Group

Social Workers identified the following challenges:

- Sexual violence generally not considered a matter of urgency
- Lack of confidence, competence among HWs
- Lack of adherence to Guiding Principles by HWs
- Absenteeism and poor motivation among HWs



FINDINGS: Focus Group

- Limited laboratory facilities/ personnel
- Insufficient trained, female providers/midwives
- At times, money is demanded by HWs or police
- As a result, many survivors fail to access timely and appropriate medical services

- ***Private facilities perceived to provide better quality services than Govt settings.***

FINDINGS: Focus Group

Social workers described their experience at health units:

- *“I have a feeling these people are just scared to give treatment”.*
- *“Just examining and filling the PF3 - they are not willing.”*
- *“No one wants to involve himself/herself...there is some element of not trusting their ability.”*
- *“Some don’t have the heart. They don’t know its something that has to be handled with care.”*

CONCLUSIONS

- Supplies are available in targeted health units
- HW general knowledge is good but HWs are not comfortable providing services
- HWs require continuous training, monitoring, and support to ensure appropriate and committed service delivery
- Poor response to survivors of GBV in rural health facilities is a significant factor in under-utilisation of services



Implications for the Field

A more strategic approach to provision of clinical management of rape services in humanitarian settings demands:

- Periodic ‘on-the-job’ monitoring, supervision and refresher training of health workers
- Targeted advocacy efforts to increase awareness of importance of post-rape medical treatment among local authorities and community leaders
- Clarification of medico-legal issues for health workers by relevant authorities; and a true Intersectoral involvement



Implications for the Field

- Building meaningful linkages between health workers and other service providers
- Government involvement in the procurement and distribution of supplies where possible
- Humanitarian agencies need to plan to build Local capacities
- ???Need to focus on larger health units(more human resource, rarely shifted)

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